Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Independent Evaluators

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-14-1288-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
January 9, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "A call was placed to the Texas Mutual bill review and auditing department on several different occasion to get clarification on how the claim was paid. I was told by representative that the DSEMG was unnecessary."

Amount in Dispute: $200.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written notification of medical fee dispute received however no position statement submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 22, 2013	96002, 96004	$200.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 784 – Service exceeds recommendation of treatment guidelines (ODG)
   - CAC-193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.

Issues

1. Did the requestor support disputed services are an exception to Division rule?
2. Is the requestor entitled to reimbursement?

Findings

1. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on January 17, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.
2. The carrier denied the disputed services as 784 – "Services exceeds recommendation of treatment guidelines (ODG)." Review of the ODG guidelines (commissioner's adopted treatment guidelines) March 2013, finds "Surface electromyography (SEMG) Not recommended for the diagnosis of neuromuscular disorders, and not in any way to replace needle EMG in the diagnosis of disorders of muscle and nerve…" "Surface EMG and F-wave tests are not very specific and therefore are not recommended, but Needle EMG and H-reflex tests are recommended. (Haig, 1996) (Greenough, 1998) (Roy, 1998) (Meyer, 1994) (BlueCross BlueShield, 2004) (CCGPP, 2005)." The disputed services are not recommended based on ODG guidelines. The carrier's denial is supported.
3. Services in dispute not recommended per ODG guidelines. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December , 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.